

DEPARTMENT OF THE NAVY

BOARD FOR CORRECTION OF NAVAL RECORDS 2 NAVY ANNEX WASHINGTON DC 20370-5100

IRE

Docket No: 4524-00

3 October 2000





This is in reference to your application for correction of your naval record pursuant to the provisions of title 10 of the United States Code, section 1552.

A three-member panel of the Board for Correction of Naval Records, sitting in executive session, considered your application on 21 September 2000. Your allegations of error and injustice were reviewed in accordance with administrative regulations and procedures applicable to the proceedings of this Board. Documentary material considered by the Board consisted of your application, together with all material submitted in support thereof, your naval record and applicable statutes, regulations and policies. In addition, the Board considered the comments of your counsel.

After careful and conscientious consideration of the entire record, the Board found that the evidence submitted was insufficient to establish the existence of probable material error or injustice. In this connection, the Board substantially concurred with the rationale of the hearing panel of the Physical Evaluation Board which considered your case on 10 November 1999. A copy of the rationale is attached. Accordingly, your application has been denied. The names and votes of the members of the panel will be furnished upon request.

It is regretted that the circumstances of your case are such that favorable action cannot be taken. You are entitled to have the Board reconsider its decision upon submission of new and material evidence or other matter not previously considered by the Board. In this regard, it is important to keep in mind that a presumption of regularity attaches to all official records. Consequently, when applying for a correction of an official naval record, the burden is on the applicant to demonstrate the existence of probable material error or injustice.

Sincerely,

W. DEAN PFEIFFER Executive Director

Enclosure

RATIONALE:

THE MEMBER IS A 26 YEAR OLD EM3, USN WITH ABOUT 5 AND ½ YEARS OF SERVICE AT THE TIME OF HER APPEARANCE BEFORE A MEDICAL BOARD AT PORTSMOUTH NAVAL MEDICAL CENTER ON 8 JANUARY 1999 WITH THE DIAGNOSES:

- (1) IDIOPATHIC CNS HYPERSOMNOLENCE;
- (2) CHRONIC MIGRAINE-VARIANT HEADACHES, WITHOUT AURA; AND
- (3) RECURRENT EPISODES OF LOS OF CONSCIOUSNESS, UNKNOWN ETIOLOGY.

ON 4 MAY 1999 THE INFORMAL PEB REQUESTED ADDITIONAL MEDICAL INFORMATION TO INCLUDE A PSYCHIATRIC ADDENDUM TO THE MEDICAL BOARD, AN UPDATE ON THE HYPERSOMNOLENCE SINCE INSTITUTION OF DEXEDRINE THERAPY, RESULTS OF A "TILT TABLE" TEST IF IT HAD BEEN PERFORMED, COPIES OF PRESERVICE EVALUATIONS, BASIS FOR A DETERMINATION OF SERVICE AGGRAVATION OF HER SYNCOPAL EPISODES, AND COPIES OF HEALTH RECORD PAGES NOT INCLUDED IN THE ORIGINAL SUBMISSION.

THE INFORMAL PEB CONSIDERED THE CASE ON 29 JUNE 1999 AND FOUND THE MEMBER UNFIT FOR DUTY BECAUSE OF PHYSICAL DISABILITY BASED ON DIAGNOSIS NUMBER 3, WHICH WAS CONSIDERED EPTE, NOT AGGRAVATED, NOT RATABLE; DIAGNOSES 1 AND 2 WERE CONSIDERED CATEGORY III CONDITIONS. THE MEMBER DISAGREED WITH THIS FINDING AND DEMANDED A FORMAL HEARING.

A FORMAL HEARING WAS CONDUCTED ON 10 NOVEMBER, 1999 AT BETHESDA, MARYLAND WITH AS PRESIDING OFFICER, AND CAPTAIN L. AND CAPTAIN AND CAPTAI

THE MEMBER APPEARED AT THE HEARING REQUESTING TO BE FOUND UNFIT FOR DUTY WITH A DISABILITY RATING OF 30% UNDER V.A. CODE 8100 WITH PLACEMENT ON THE TDRL. TO SUPPORT HER REQUEST THE MEMBER PRESENTED TESTIMONY, COPIES OF HEALTH RECORD ENTRIES MADE SINCE THE SUBMISSION OF THE MEDICAL BOARD, AND NON-MEDICAL EVIDENCE LETTERS FROM TWO SUPERVISORS AND SUPERVISORS AND SUPERVISORS AND SUPERVISORS AND SUPERVISORS OF A MEMORANDUM FROM HER NEUROLOGIST TO HER COMMAND, A COPY OF A MEMORANDUM FROM EMC WILSON TO ASSESSED.

HER TAD REQUESTS DATED 24 MAY AND 14 SEPTEMBER 1999. THE MEMBER ALSO MADE HER HEALTH AND SERVICE RECORDS AVAILABLE FOR REVIEW.

AFTER CAREFUL REVIEW OF ALL THE AVAILABLE EVIDENCE AND BASED ON UNANIMOUS OPINION, THE FORMAL PEB FINDS THE MEMBER IS UNFIT FOR DUTY IN THE U.S. NAVY BECAUSE OF PHYSICAL DISABILITY. THE RECORD DOCUMENTS THAT THE MEMBER HAS A HISTORY OF RECURRENT EPISODES OF "LOSS OF CONSCIOUSNESS" DESCRIBED AT TIMES AS "BLACK OUT" OR SYNCOPE WITH COLLAPSE TO THE FLOOR, BLANK STARE, AND ABILITY TO HEAR WHAT IS BEING SAID AROUND HER, BUT NO REPORTED INJURIES DURING AN EPISODE. EXTENSIVE NEUROLOGY AND CARDIOLOGY EVALUATION HAS FAILED TO DETERMINE A CAUSE. THESE EPISODES LIMIT HER ASSIGNABILITY TO NON-HAZARDOUS DUTIES NEAR A MAJOR MEDICAL FACILITY.

ALTHOUGH THERE ARE MULTIPLE HEALTH RECORD ENTRIES INDICATING THAT HER EPISODES OF LOSS OF CONSCIOUSNESS EXISTED PRIOR TO HER ENTERING THE NAVY ON 23 MARCH 1993 (SEE ENTRIES: E.R. VISIT AND CARDIOLOGY CONSULT DATED 29 JUNE 1994, SF600'S OF 21 AND 25 APRIL 1995 AND 10 FEBRUARY AND 8 MARCH 1997, AND A CONSULTATION REQUEST OF 2 MAY 1995 WITH EVALUATION ON 12 MAY 1995). THE MEMBER PERSISTED IN CLAIMING AT THE HEARING THAT SHE ONLY HAD ONE SYNCOPAL EPISODE PRIOR TO ENTRY, WHICH WAS RELATED TO ONSET OF MENSES AT AGE 10 AND PROMPTED THE THREE DAY HOSPITALIZATION FOR EVALUATION. THE MULTIPLE ENTRIES CITED ABOVE ALL CLEARLY INDICATED THE MEMBER EXPERIENCED MULTIPLE EPISODES OF LOSS OF CONSCIOUSNESS FROM AGE 10 TO AGE 14 OR 15 WITH A FREQUENCY VARYING AMONG THE ENTRIES FROM 1 EVERY 2 TO 3 MONTHS VERSUS 6 PER YEAR VERSUS "ALMOST WEEKLY." THE ENTRY OF 25 APRIL 1995 INDICATED THE EPISODES STARTED AGAIN AT AGE 17 WHILE THE ENTRY OF 21 APRIL 1995 INDICATED THEY RECURRED AT AGE 19 DURING HER FIRST YEAR OF COLLEGE. IT WAS NOTED AT THE HEARING THAT ALL OF THE ABOVE CITED ENTRIES, EXCEPT FOR THE 2 MAY 1995 CONSULTATION REQUEST, HAD BEEN REMOVED FROM THE MEMBER'S HEALTH RECORD. WHEN CONFRONTED WITH THIS, THE MEMBER CLAIMED THAT SHE HAD REMOVED THESE ENTRIES TO MAKE COPIES FOR CDR PANETTIERE AND HAD "JUST NOT GOTTEN AROUND TO PUTTING THEM BACK YET." THE FORMAL PEB PANEL MEMBERS DID NOT FIND THE MEMBER'S TESTIMONY CREDIBLE. A NUMBER OF THE ENTRIES INDICATED THE MEMBER ALSO HAD HEADACHES PRIOR TO ENTRY AS WELL, INCLUDING THE ENTRIES OF 10 FEBRUARY 1997 AND 25 APRIL 1995, AS WELL AS THE LIMITED DUTY MEDICAL BOARD AND HEALTH RECORD ENTRY DATED 12 MARCH 1997 AND THE CONSULT REQUEST DATED 8 MARCH 1997 INDICATING PROGRESSIVE SEVERITY AND FREQUENCY OF MIGRAINE HEADACHES SINCE 1988. THE MEMBER INDICATES SHE

ALWAYS HAS A HEADACHE ASSOCIATED WITH THE EPISODES OF LOSS OF CONSCIOUSNESS BUT DOES NOT ALWAYS HAVE A LOSS OF CONSCIOUSNESS WITH A HEADACHE. THE MEMBER'S EPISODES OF LOSS OF CONSCIOUSNESS HAVE OCCURRED OVER THE PAST YEAR ONCE IN SEPTEMBER OR AUGUST AND ON 6 AND 11 MAY 1999 AND ON 23 NOVEMBER 1998. THE FORMAL PEB IS NOT CONVINCED THAT THERE HAS BEEN A TRUE WORSENING OF THE MEMBER'S CONDITION ON ACTIVE DUTY RELATIVE TO HER PRESERVICE CONDITION. THEREFORE, THE DISABILITY IS APPROPRIATELY CONSIDERED EPTS, NOT AGGRAVATED, NOT RATABLE.

ALTHOUGH THE MEMBER' CLAIMS TO HAVE VERY FREQUENT INCAPACITATING MIGRAINE HEADACHES, THE RECORDS PRESENTED ONLY DOCUMENT HEADACHES REQUIRING E.R. VISITS ON 13 SEPTEMBER, 12 JULY, AND 6 MAY 1999. AT THIS FREQUENCY, THE HEADACHES ARE NOT CONSIDERED TO PRECLUDE THE CONTINUED PERFORMANCE OF DUTIES. HOWEVER, THE HEADACHES COULD BE A PART OF THE SAME PROCESS AS THE EPISODES OF LOSS OF CONSCIOUSNESS, IN WHICH CASE THE HEADACHES WOULD BE A CATEGORY II CONDITION AND ALSO EPTS, NOT AGGRAVATED, NOT RATABLE. THE FORMAL PEB, HOWEVER, CONSIDERS THIS A CATEGORY III CONDITION THAT IS NOT SEPARATELY UNFITTING OR CONTRIBUTING TO THE UNFITTING CONDITION.

THE IDIOPATHIC DAYTIME HYPERSOMNOLENCE IS NOTED IN THE RECENT HEALTH RECORD ENTRIES TO BE RELATED TO POOR SLEEP HYGIENE. FURTHER, THERE IS NO DOCUMENTATION SINCE INSTITUTION OF DEXEDRINE THERAPY THAT THIS INTERFERES WITH THE PERFORMANCE OF DUTIES. THEREFORE, THIS IS ALSO CONSIDERED A CATEGORY III CONDITION.